

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

P.O. Box 71010

Oakland, CA 94612

(510) 286-3700 or (800) 794-6900

INJURED WORKER INFORMATION

Panel #: _____

Date Request Received:

Date Mailed:

Claim No.:

Date of Injury:

Employer:

No. of Req.:

Ins.Adj./Agency:

Requested by:

To:

TYPE OF EXAM: () 4060 () 4061 () 4062 () 4061 and 4062

SELECTED QUALIFIED MEDICAL EVALUATOR PANEL:

PHYSICIAN'S NAME:

ADDRESS:

PHONE:

SPECIALTY:

YEARS IN PRACTICE:

PHYSICIAN'S EDUCATION:

PHYSICIAN'S TRAINING:

PHYSICIAN'S NAME:

ADDRESS:

PHONE:

SPECIALTY:

YEARS IN PRACTICE:

PHYSICIAN'S EDUCATION:

PHYSICIAN'S TRAINING:

PHYSICIAN'S NAME:

ADDRESS:

PHONE:

SPECIALTY:

YEARS IN PRACTICE:

PHYSICIAN'S EDUCATION:

PHYSICIAN'S TRAINING: